Work-related post-traumatic stress symptoms in obstetricians and gynaecologists: findings from INDIGO a mixed methods study with a cross–sectional survey and in-depth interviews.

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Work-related trauma in obstetrics and gynaecology

Abstract

Objectives

To explore Obstetricians' and Gynaecologists'(O&G) experiences of work-related traumatic events, to measure the prevalence and predictors of posttraumatic stress disorder (PTSD), any impacts on personal and professional lives, and any support needs.

Design

Mixed methods: cross–sectional survey and in-depth interviews.

Sample and Setting

Fellows, members and trainees of the Royal College of Obstetricians and Gynaecologists (RCOG).

Methods

A survey was sent to 6300 fellows, members and trainees of RCOG. 1095 people responded. Then 43 in-depth interviews with trauma-exposed participants were completed and analysed by Template Analysis.

Main Outcome Measures

Exposure to traumatic work–related events and PTSD, personal and professional impacts, and whether there was any need for support. Interviews explored the impact of trauma, what helped or hindered psychological recovery, and any assistance wanted.

Results

Two thirds reported exposure to traumatic work-related events. Of these, 18% of both consultants and trainees reported clinically significant PTSD symptoms. Staff of black or minority ethnicity were at increased risk of PTSD. Clinically significant PTSD symptoms were associated with lower job satisfaction, emotional exhaustion and depersonalisation. Organisational impacts included sick leave, and 'seriously considering leaving the profession'. 91% wanted a system of care. The culture in obstetrics and gynaecology was identified as a barrier to trauma support. A strategy to manage the impact of work-place trauma is proposed.

Conclusions

Exposure to work-related trauma is a feature of the experience of obstetricians and gynaecologists. Some will suffer PTSD with high personal, professional and organisational impacts. A system of care is needed.

Funding

The work was funded by Grant RG1912 from Wellbeing of Women. The grant was awarded after external peer review for scientific quality. Wellbeing of Women had no role in the conduct of the research or writing of the paper

Key Words: Trauma, obstetrics and gynaecology, post traumatic stress disorder, work place

Tweetable abstract

18% of O&G doctors experience post traumatic stress disorder after traumatic events at work.

Introduction

The impact of doctors' work on their mental health is now a major global concern[1-4]. The mental health of the medical work force affects the wellbeing of doctors and their families and the care they can provide for patients. High levels of burnout have been reported amongst obstetricians and gynaecologists[5]. Doctors can be exposed at work to events that they find traumatic, and obstetricians and gynaecologists may be particularly at risk. Whilst the majority of births proceed straightforwardly to positive outcomes, adverse events in which a previously healthy mother or her baby is suddenly at risk of serious injury or death are frequent.

Exposure to trauma through the provision of care can lead to work-related post traumatic stress disorder (PTSD). This is defined as a psychological response to exposure to an event involving actual (or threatened) death or serious injury and characterised by four symptom

groups:(1) intrusions (e.g. intrusive thoughts or images, flashbacks), (2) avoidance of reminders, (3) arousal (e.g. feeling 'on edge') and (4) negative alterations to beliefs or mood (e.g. anger, guilt)[6]. These symptoms cause distress, impairment in the individual's social interactions, capacity to work or in other important areas of functioning. At least 5% of midwives suffer with work-related PTSD[7] and show increased levels of emotional exhaustion and an increased tendency to depersonalise recipients of care. Other consequences included increased sick leave and staff turnover, with implications for organisational costs.

Wallbank and Robertson[8] in a study of midwives, nurses and doctors found that some staff developed symptoms of PTSD after a stillbirth, miscarriage or neonatal death. However, it was impossible to disaggregate responses of doctors. Whilst there are similarities in clinical events encountered by midwives and obstetricians and gynaecologists, direct extrapolation is unwarranted because of the differences in training and roles. The only study of prevalence of PTSD specifically in obstetricians was in the Netherlands where obstetric staff have a very different working role and client group[9]. A small qualitative study with Irish consultants highlighted the impact of stillbirth and, although not framed within the context of trauma, the responses documented reflected elements of PTSD[10]. Given the potential personal and organisational implications a systematic study of PTSD in the obstetric work force in England is needed.

Study Objective

To explore obstetricians' and gynaecologists' experiences of work-related traumatic events, to measure the prevalence and predictors of PTSD any impacts on personal and professional lives, and any support needs.

Methods

The work was overseen throughout by a study management group with representation from a consultant, a trainee, and a senior elected representative from the Royal College of Obstetricians and Gynaecologists. Patient and public involvement is complex in this context as this study concerns the mental health of obstetricians and gynaecologists rather than patients directly. Individuals from the profession were therefore involved at every level and stage from inception, design, implementation, analysis, interpretation and to paper preparation.

Stage 1. Survey of Members and Fellows

In collaboration with the Royal College of Obstetricians and Gynaecologists (RCOG), a national survey was conducted with fellows, members and trainees to provide information on the frequency and impact of experiencing traumatic work–related events, measure prevalence of PTSD and assess symptoms of burnout. The survey was sent by email to 6300 doctors on the RCOG database (retired members were excluded): 4750 consultants/associate specialists and 1550 trainees/staff grade doctors. Responses were returned anonymously direct to the researchers and not accessible by RCOG.

The survey covered the following:

Demographic details, professional designation and number of traumatic perinatal event experiences. Standardised scales were used to measure:

1. *Post traumatic stress disorder:* The Impact of Event Scale Revised.[11] This measures symptoms of intrusion, avoidance and arousal. A cut off of equal or >33 has been demonstrated to indicate symptoms of PTSD commensurate with a clinical diagnosis whilst subclinical levels are defined as 22 to 32.[12]

2. *Burnout:* The Maslach Burnout Inventory[13], which measures three domains of burnout including emotional exhaustion, depersonalisation and personal accomplishment.
3. *Perceived Impairment:* Sheehan Disability Scale[14]. This assesses the degree to which a traumatic perinatal event is perceived to have disrupted work, social and family/home life.
4. *Empathy:* Interpersonal Reactivity Index[15] (Empathic Concern subscale), measuring the degree of empathic concern felt for other individuals.
5. *Job Satisfaction*: Attitudes to Professional Role scale[16] measuring professional satisfaction, professional support, client interaction professional development.
6. Two additional questions were included as to whether specific support for obstetricians and gynaecologists following a traumatic event was needed (Yes/ No) and if 'Yes', what participants thought would be helpful to support them in dealing with workplace traumatic events.

Core outcome sets are not relevant in this context. Planned analyses were as follows: Consultant/associate specialists and trainee/staff grade groups were disaggregated to check for differences. Descriptive statistics were computed for the number of traumatic perinatal events experienced and scores on the measures for PTSD, burnout, perceived impairment and empathy. Correlation analyses, t-tests and ANOVAs (independent measures) were conducted to inspect initial associations and differences between PTSD scores according to personal experience variables (age, professional experience, prior trauma history), burnout and perceived impairment. Appropriate regression analyses were completed after bivariate inspection. Open questions were analysed by simple content analysis[17].

Stage 2. Qualitative interviews

At the end of the online survey, respondents indicated if they were willing to participate in a telephone interview about their trauma experience, to provide in-depth information on the nature of impacts of these experiences and any helpful or supportive strategies. We aimed to complete 40 in-depth interviews with two purposively sampled groups in which all reported trauma exposure. Of these, twenty participants would have high symptoms of PTSD (> or equal to 33 on the IES-R suggested diagnostic cut off) and a high score (5) on the Sheehan Disability Scale for impact on work (PTSD GROUP). Twenty others would have no significant symptoms of PTSD in relation to trauma exposure (below 22 on IES-R) and no significant perceived work impairment (i.e. scored below 3 on the work dimension of the Sheehan Disability Scale; (NO PTSD GROUP).

All interviews were audio recorded and transcribed. Information from the two groups was analysed separately using Template Analysis[18]. This allows for the same initial outline template of main areas of enquiry but with emergent themes and subthemes. The outline template included the following: what made events traumatic, what were the impacts, in managing impacts what helped, what hindered and what was wanted. The primary analysis was conducted by KB. This was checked throughout progress by members of the team (KS LG and PS) to ensure appropriate identification and labelling of the constituent themes with repeated checking of the evidential basis. PTSD and NO PTSD groups were then compared for consistencies and differences in emergent themes and subthemes.

Results

Stage 1. Survey of Members and Fellows

Participants

A total of 1095 participants responded to the electronic survey. Sub-groups were formed to compare demographics and experiences according to respondents' current level of responsibility: trainee / staff grades including those currently out of the programme (n= 447, 40.6% of the sample), consultant / associate specialist roles (n= 624, 56.7%), or those no longer working in clinical obstetrics and gynaecology (n= 24, 2.2%). A flow chart showing the participation process within the survey is shown in Figure S1. Sample characteristics are shown in Table S1. Overall response rate was 18%.

Exposure to trauma and post traumatic stress

Approximately two third of trainees and consultants reported exposure to work related events that they found personally traumatic, defined as a situation where they had "experienced fear, helplessness, or horror in response to perceived threat of death or damage to someone in their care" (Table 1).

Of those reporting such trauma exposure, 31% of trainees/staff grade and consultants were affected by PTSD symptoms : 18% each of trainees/staff grade and of consultants/associate specialists reported PTSD symptoms in relation to work trauma exposure at clinical levels, with a further 13% and 14% respectively at subclinical levels (Table 1).

Risk factors for clinical PTSD in staff overall were being of black or minority ethnicity and having a lower levels of perceived support in the workplace. Consultants/associate specialists with clinical PTSD also reported a larger number of traumatic events (Table S2).

Clinically significant PTSD symptoms were associated with lower job satisfaction and higher impairment in relation to work home and social lives for both trainees and consultants (Table 2).

Organisational Impacts

There were organisational impacts of work-related trauma with 14% of trainees and 11% of consultants reporting having taken sick leave as a result of it. The sick leave lasted for 1 week or less for half of the trainees, whilst for 26.7% it lasted over a month. For consultants, 20% had trauma-related sick leave of a week or less, 32% reported 1 week to 1 month and 47% over a month. As a result of trauma, 20% of trainees and 12% of consultants had short term changes in duty allocation, whilst 60% of trainees and 30% of consultants seriously considered leaving the specialty.

Trainees with clinical level PTSD were more likely than their colleagues to have asked for a short-term change in clinical duties, to have seriously considered changing speciality, or taken reduced hours or a career break. However, they were no more likely to have taken related sick leave. Compared to non-distressed colleagues, consultants with clinical level PTSD were about twice more likely to have asked for an amended short-term or long-term allocation, taken stress related sick leave, seriously considered changing speciality or taken reduced hours or a career break (Table S3).

For the whole sample (with or without trauma exposure), levels of burnout were high with 30% reporting high emotional exhaustion (rates were higher in trainees, 35% vs 26%) and 28% reported high or moderate depersonalisation of those in their care. Feelings of low personal accomplishment affected 23% and 19% of trainees and consultants respectively. Clinical levels of PTSD were associated with greater emotional exhaustion and increased depersonalisation but not lower personal accomplishment. (Table 3).

What was wanted?

A total of 91% (N= 764/839) of participants felt specific support in relation to trauma responses should be provided. This was consistent across consultant and trainees and was

strongly supported whether or not the staff member themselves had experienced an event as traumatic.

Three themes were identified in the open responses:

Response after the traumatic event: Participants identified the importance of having someone available to discuss the event relatively soon afterwards; this could include either senior colleagues or a dedicated team. Some also suggested that it might be helpful to have the option of time-off after a traumatic event.

Factors that would facilitate implementation of a support system: Participants felt that any training around trauma must be regular and mandatory. This could be achieved through embedding it into the training process with ring-fenced time. It was also noted that the most beneficial training would include relevant information about how to manage factors that compound the traumatic experience for obstetricians and gynaecologists e.g. attending coroner's court.

Need to address the culture within obstetrics and gynaecology: A programme would need to be well supported by managers and valued by clinical management to gain traction. It was highlighted that the current culture around traumatic work-related events needs to be addressed to try and generate a culture of support rather than blame, and to destigmatise the need to access help after a work-related traumatic event.

Stage 2 : Interviews

Participants

Forty-three interviews were conducted: 20 in the PTSD group and 23 in the NO PTSD group.

In the PTSD group, 11 were consultant/associate specialist grade, 7 were trainee/ staff grade and 2 were other RCOG members. In the NO PTSD group, 17 were consultant/associate specialist grade, 5 were trainee/ staff grade and 1 was an RCOG member not currently working in obstetrics and gynaecology. The average age of respondents was 45 years (SD= 9.34); participants in the NO PTSD group were aged on average slightly older (M= 46.17, SD= 9.50) than those in the PTSD group (42.45, SD= 9.0). The majority of participants were female (N= 38, 88%), of white or white British ethnicity (N= 32, 74%) and married or cohabiting (N= 35, 81.4%). Those in the PTSD reported more traumatic events and the most difficult event was more recent but these differences were not statistically significant.

Findings

There were relatively few thematic differences between the groups. The original, and final template of themes is shown in Table 4. Table S4 shows exemplar quotes for the each theme and subtheme.

Theme labels from the outline template are shown below in bold, emergent main themes (bold italics) and subthemes (all emergent) in italics. The first theme of **What made events distressing** is outside the main focus of the paper and will be presented elsewhere**.**

The impacts of traumatic events were experienced both immediately and in the longer term. They affected all aspects of personal and professional lives leading to *high levels of anxiety around particular procedures or more generally in the workplac*e and in some cases *a distancing from engagement with patients*. There was *consideration of leaving* and *a loss of pleasure in the work*. There were positives in terms of *learning* and also of *supporting colleagues better*. Those in the NO PTSD had used their experiences *to train others* to enable them to benefit.

What helped in managing the impact of traumatic events was focussed on *sharing of the experience with a supportive te*am and *support from seniors preventing a sense of isolation*. In particular, the NO PTSD reported help from receiving *support and time to process the event*. For both PTSD and NO PTSD groups , the *role of support from family/ friends* and external input was noted.

What hindered was the converse of what helped i.e. *the event or its impact being ignored* or *no opportunities to process the event, being given minimal or 'flippant support'*, or *support from those poor at supporting*, or *being criticised or gossiped about in relation to the event.*

What was wanted was *an open and honest discussion with someone supportive* and *someone in the system checking on how they were*.

How support should be provided participants thought there needed to be *a change in culture* so that the expectation was not *just to 'carry on'*. They suggested that provision of *support should be routinely embedded in the system, the need for support after traumatic events should be normalized rather than stigmatized* and *routinely provided for all after trauma, with assured confidentiality and supported in time and funding.*

Aspects of the culture in O&G made staff feel unsupported in relation to trauma events was an emergent major theme with subthemes focussing on the system supporting *a 'carry on regardless' approach,* and *doctors mental health not being considered* and there being culture of blame and criticism and *stigma in asking for help*.

Discussion

Main findings

Trainees and consultants in obstetrics and gynaecology are routinely exposed to events at work that they experience as traumatic. As a result, 18% report clinical levels of PTSD with a further 13% reporting subclinical symptoms These responses were linked to high levels of anxiety in the specific situations resonating with the original event or more generally which in turn led to changes in professional practice to become more defensive and interventionist. Those with PTSD reported providing less sensitive care and having higher rates of stress-related sickness. Both trainee/staff grades and consultants/associate specialists reported that these traumatic experiences and their consequences are not routinely acknowledged within the speciality, that informal and formal systems of support are often lacking and that an unsupportive culture exists. The higher risk for PTSD in BME staff requires further consideration. It is clear that low perceptions of support are a key risk factor for PTSD. The Fair to Refer report[19] investigating high rates of referral of BME doctors to the General Medical Council identifies an in-group/out-group culture which may well mitigate against a supportive working environment for BME doctors. Suffering from PTSD may also be a previously unidentified factor underpinning less sensitive care and poorer relationships with colleagues which may place BME doctors at greater risk of referral.

A final key finding is that whether or not they were personally distressed, respondents thought that changes in culture and systems of care were urgently needed.

Strengths and limitations

The major limitation is the 18% response rate. Interestingly, this rate of response is consistent across nearly all studies of work-related traumatisation across different professional groups[7, 20,21]. Whilst the demographic pattern of participation in the current study is reasonably representative of the speciality, reasons for participation and non-participation are likely to bias findings in both directions. Firstly, those who are unaffected may have no interest in the topic and may be less likely to participate, even though the invitation

specifically encouraged recipients to respond whether or not they felt it personally relevant. Secondly, avoidance of all associated experiences is a feature of PTSD because of fears of re-experiencing distress. Therefore, those more highly distressed are also likely to have avoided participation. This is evidenced by an examination of the timing of respondent drop-out in the survey: at the point of having to briefly describe the trauma, 25% of those with a trauma experience stopped completing the survey, compared to just 2.5% for those without.

It is also notable that interviewees were often highly emotional when talking about their experience and frequently commented to the clinical psychologist interviewer how this was the first time they had really done so and how they welcomed this despite their distress. This suggests that for most, the material had never been adequately processed and was continuing to impact on thememotionally. The response rate does mean that PTSD rates may be less that the disturbing 18% but it is equally possible that this may be an underestimate within the profession. Given the potential implications for mental health, known impacts on care and the ongoing crisis in trainee attrition to ignore this finding would seem reckless. Nevertheless, the low response rate means that absolute rates of PTSD in this study need to be considered with caution.

Interpretation

A system of care and efforts to generate cultural changes in the speciality are needed. These findings mirror those from midwifery staff [7] and suggest an unmet need at the level of the maternity workforce. Maternity staff may be particularly vulnerable in that they work in an environment that is focussed on new life and hope rather than illness, recovery or death. When an outcome is adverse for baby or mother it can be swift and unexpected, and generate complex emotions. Addressing staff needs to intervene to protect staff from harm in the workplace is the responsibility of an employer. This is also in keeping with the focus on staff

wellbeing in the implementation NHS plan for the 5 year Forward View Implementation Plan[22] and Health Education England's current published priorities[23]. The current loss rate from this speciality during junior doctor training is up to 30%, which is both wasteful and unsustainable[24]. Whilst many factors are implicated, exposure to trauma is most certainly one which is now known and could be actively addressed.

Conclusions

High rates of PTSD symptoms occur in obstetric and gynaecological trainees and consultants, especially those who are black or from ethnic minorities. Doctors describe considerable negative effects on their life and work. Their clinical practice is also affected, resulting in high rates of clinical intervention as well as insensitive and defensive care. Both those affected and unaffected describe a culture of denial and blame within the workplace, and suggest a range of interventions that could assist in prevention and the care of those affected.

As a result we propose a strategic plan which can address this issue through (i) education of staff about trauma and self-help methods which can reduce the probability that trauma exposure leads to the development of PTSD to be provided for trainees, staff grade doctors and consultants (ii) the development of a system of routinely provided support after any serious incident but also available to staff after any incident regardless of outcome from a trained workplace trauma champion within each trust (iii) rapid access to trauma focussed psychological intervention (iv) reviews of trust guidelines after serious incidents to ensure staff care is included. Whilst this is tailored for the specific needs of the profession, this mirrors some of the initiatives which have already shown positive potential in the midwifery workforce and opens up the potential for a whole maternity workforce approach to this unmet need[25]. Future research needs to systematically evaluate the implementation of such systems of support in aiming to prevent the experience of traumatic events leading to PTSD and in

385 turn burnout, stress-related sickness and/or attrition from training**.** Reviews of organisational
386 change strategies[26,27] which have considered the development of trauma informed workforces
387 have aimed to change at client care level rather than directed at staff themselves. There is a
388 gap in evidence for what works which now needs to be addressed.

389

390 **Funding**

391 The work was funded by Grant RG1912 from Wellbeing of Women. The grant was awarded
392 after external peer review for scientific quality. Wellbeing of Women had no role in the
393 conduct of the research or writing of the paper

394

395 **Ethical Approval**

396 Ethical approval for the study was obtained from the University of Liverpool Ethics
397 Committee (UoLREC1171) on 2nd March 2017 and all participants provided informed
398 consent.

399

400 **Competing Interests Statement**

401 All authors have completed the ICMJE uniform disclosure form at
402 http://www.icmje.org/coi_disclosure.pdf and declare: no support from or any financial
403 relationships with any organisations that might have an interest in the submitted work in the
404 previous three years and no other relationships or activities that could appear to have
405 influenced the submitted work.

406

407 **Contributions to authorship**

PS was responsible for design, led the bid for funding and oversaw all aspects of the project and paper. KB implemented the survey, completed all qualitative interviews and analyses and contributed to the paper. KS contributed to the funded proposal and led the analysis of the quantitative data, contributed to qualitative analysis and all drafts of the paper. LG contributed to implementation, qualitative analysis, interpretation and drafts of the paper. HS was instrumental in design, obtaining the funding, implementation, interpretation and the paper. JR facilitated the running of the project via the Royal College of Obstetricians and Gynaecologists and contributed to interpretation and the paper. AW contributed to the design, obtaining the funding, interpretation and the paper.

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Table 1. Presence of self-reported work-related trauma and rates of PTSD symptoms in respondents reporting work-related traumatic experiences split by total Impact of Event Scale-Revised score (IES-R) and categorised by clinical and subclinical threshold. Note. [a]Work-related trauma experience inferred via endorsement of Criterion A1 and A2 of DSM-IV-TR; event involving actual or perceived threat to life, where the respondent appraised this with fear, helplessness or horror. [b]Total scores on the Impact of Event Scale-Revised (IES-R) for respondents reporting work-related trauma and IES-R scores.

		Trainee/ staff grade with trauma exposure (N= 447)	Consultant/ associate specialist with trauma exposure (N= 624)	RCOG members working outside of clinical O&G with trauma exposure (N= 24)	Total (N= 1095)
Work related trauma exposure[a]	Yes	304 (68.0)	404 (64.7)	20 (83.3)	728 (66.5)
	No	143 (32.0)	220 (35.3)	4 (16.7)	367 (33.5)
Total IES-R (0-88)[b]	N[b]	207	302	17	526
	Mean (SD)	16.27 (15.69)	16.26 (15.00)	19.76 (20.74)	16.37 (15.46)
	Median (range)	11(76)	12(87)	15(77)	12(87)
IES-R Categorisations by clinical and subclinical thresholds					
N (%) Subclinical only (≥22 ≤32)		26 (12.6)	43 (14.2)	1 (5.9)	70 (13.3)
N (%) Clinical only (≥33)		37 (17.9)	53 (17.5)	4 (23.5)	94 (17.9)
N (%) Subclinical and Clinical combined (≥22)		63 (30.4)	96 (31.8)	5 (29.4)	164 (31.2)

Table 2. Levels of job satisfaction (Professional Attitudes to Role Scale) and perceived impairment (Sheehan Disability Scale) for respondents reporting clinical levels of PTSD symptoms and all those with trauma experience scoring below clinical threshold, split by level of responsibility. Note. *p<.05, **p<.01, ***p<.001

		Trainees/staff grade			Consultants/associate specialists			Trainees/staff grade and consultants/associate specialists		
		Clinical PTSD (n=37)	<clinical PTSD (n=166)	sig.	Clinical PTSD (n=53)	<clinical PTSD (n=240)	sig.	Clinical PTSD (n=90)	<clinical PTSD (n=406)	sig.
Job Satisfaction	Professional satisfaction	-.04 (.44)	-.04 (.41)	.967	-.21 (.56)	-.06 (.42)	.032*	-.14 (.52)	-.05 (.42)	.096
	Professional Support	-.22 (.66)	.01 (.62)	.047*	-.26 (.72)	.12 (.55)	<.001***	-.25 (.70)	.07 (.58)	<.001
	Client Interaction	-.20 (.51)	-.15 (.43)	.56	-.25 (.45)	-.30 (.40)	.455	-.23 (.47)	-.24 (.42)	.903
	Professional Development	-.25 (.64)	-.18 (.51)	.52	-.43 (.69)	-.11 (.52)	.002**	-.36 (.68)	-.14 (.51)	.005**
		Trainees/staff grade			Consultants/associate specialists			Trainees/staff grade and consultants/associate specialists		
		Clinical PTSD (n=37)	<clinical PTSD (n=169)	sig.	Clinical PTSD (n=53)	<clinical PTSD (n=248)	sig.	Clinical PTSD (n=90)	<clinical PTSD (n=417)	sig.
Perceived impairment following traumatic experience	Work	5.65 (2.44)	3.87 (2.61)	<.001***	5.87 (2.63)	3.39 (2.51)	<.001***	5.78 (2.53)	3.58 (2.56)	<.001***
	Family/home	7.16 (2.38)	3.91 (3.11)	<.001***	6.87 (2.59)	4.01 (3.11)	<.001***	6.99 (2.49)	3.97 (3.11)	<.001***
	Social	6.03 (2.60)	3.22 (2.79)	<.001***	6.38 (3.0)	3.47 (3.05)	<.001***	6.23 (2.80)	3.37 (2.95)	<.001***

Table 3. Levels of burnout across the total sample split by level of responsibility. Total sample includes all available data for the MBI irrespective of work-related trauma exposure (n= 854)

	Level of responsibility			
	Trainee/ staff grade (n= 332)	Consultant/ associate specialist (n= 503)	RCOG members working outside of clinical O&G (n= 19)	Overall (n= 854)
Emotional Exhaustion				
N (%) High	116 (34.9)	133 (26.4)	9 (47.4)	258 (30.2)
N (%) Moderate	116 (34.9)	160 (31.8)	3 (15.8)	279 (32.7)
N (%) Low	100 (30.1)	210 (41.7)	7 (36.8)	317 (37.1)
Depersonalisation				
N (%) High	37 (11.1)	24 (4.8)	3 (15.8)	64 (7.5)
N (%) Moderate	88 (26.5)	85 (16.9)	3 (15.8)	176 (20.6)
N (%) Low	207 (62.3)	394 (78.3)	13 (68.4)	614 (72.0)
Personal Accomplishment				
N (%) High	116 (34.9)	200 (39.8)	5 (26.3)	321 (37.6)
N (%) Moderate	139 (41.9)	206 (41.0)	7 (36.8)	352 (41.2)
N (%) Low	77 (23.2)	97 (19.3)	7 (36.8)	181 (21.2)

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Table 4. Final template

1.Impact of the event	1.1 During event	1.1.1 Intense feelings
		1.1.2 Having to contain emotions
	1.2 Immediately after event	1.2.1 Tearful, deflated/sad
	1.3 Long term after event	1.3.1 Impact on daily life and relationships
		1.3.2 Constantly thinking about the event
		1.3.3 It has got better (PTSD GROUP ONLY)
		1.3.4 Puts things into perspective (no PTSD group only)
	1.4 Impact on practice	1.4.1 Anxiety around the job (generally and when doing a similar procedure)
		1.4.2 Considered leaving O&G/Left O&G/Looking forward to retirement
		1.4.3 Questioned whether good enough for O&G/Doubted ability
		1.4.4 Feeling less positive and more detached from the job
		1.4.5 Learned from the experience and matured as a professional
		1.4.6 Made me support colleagues better and shaped the supportive doctor I would like to become
		1.4.7 Trained others so that they benefit from the experience (no PTSD group only)
2. Support – What helped, what hindered and what would you have wanted	2.1 What helped	2.1.1 Working in an available and supportive team who share ideas and stop the doctor from feeling alone
		2.1.2 Family and (non-colleague) friend support
		2.1.3 Colleagues actively supporting the doctor to allow them time to process the event (no PTSD group only)
		2.1.4 Offers of informal/formal support from seniors that never blamed the doctor and gave an opportunity to make sense of it and talk through the impact
		2.1.5 Informal positive discussions with the team
		2.1.6 External support services (GP's, Psychologists, Legal support)
		2.1.7 Closure on the case
	2.2 What hindered	2.2.1 No opportunity to process the event and no checking whether the doctor is alright after the event
		2.2.2 Flippant support from the team or inappropriate support from those who are poor at supporting
		2.2.3 Being criticised or talked about by others
	2.3 What would you have wanted	2.3.1 An open and honest discussion about the event with the seniors and the rest of the team involved
		2.3.2 Someone checking I was alright and what I needed (including time off)
3. Issues to consider in obstetrics and gynaecology and important components of care packages	3.1 These events do happen in O&G but the culture is to 'carry on' – therefore a doctor's wellbeing is rarely considered	
	3.2 Colleagues are often critical of each other and appointing blame	
	3.3 Currently support for work-related traumatic events is ad-hoc/limited	
	3.4 Care for doctors' wellbeing needs to be built in and part of a process (the offer of time-off)	
	3.5 Routinely offer support so that it reduces stigma	
	3.6 Support needs to be offered by those who are good at supporting	
	3.7 There will be barriers: Need to ring fence time. Reduce stigma of asking for help. Accept some doctors will not feel they need it. Need to properly fund it and it will need to be highly confidential.	

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